STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86506-001**
v

Priority Health
Respondent
_____/

Issued and entered
this 28th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 28, 2007, XXXXX, on behalf of his minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* On December 4, 2007, after a preliminary review of the material submitted, the Commissioner accepted the request.

The Petitioner had health care coverage from Care Choices, a health maintenance organization (HMO). On March 27, 2007, Care Choices surrendered its certificate of authority and is no longer licensed to conduct business as an HMO. Priority Health HMO acquired Care Choices' assets and liabilities and now underwrites Care Choices' coverage. Priority Health handled the Petitioner's grievance and is the Respondent in this external review.

The issue in this matter can be resolved by applying the terms of coverage as explained in the Care Choices HMO subscriber certificate (the certificate). It is not necessary to get a

medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

The Petitioner, born XXXXXXXXX, 1999, has pronated ankles and feet. On April 9, 2007, he obtained orthotic shoe inserts from XXXXX, and has been wearing them in hopes of correcting the problem and avoiding the need for surgery. The Petitioner is appealing Priority Health's decision to deny coverage for the orthotic inserts.

The Petitioner exhausted the Priority Health internal grievance process and received its final adverse determination letter dated November 6, 2007.

III
ISSUE

Did Priority Health properly deny the Petitioner coverage for the shoe inserts received from Dr. XXXXX on April 9, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's father believes the orthotics are medically necessary because of the severe pronation of his son's feet and ankles. He thinks Priority Health should provide coverage because its own customer service representative told him that these devices are typically covered when inserts are attached to braces or there is a clear medical need with proper authorization. He is therefore requesting that Priority Health cover the devices (as his other insurance plans have in the past) because there is a clear medical need.

The Petitioner's father also says Priority Health has given confusing and conflicting reasons for denying coverage. He says that in its first two letters Priority Health gave as its reasons for denying coverage that treatment for flat feet is excluded and also that Dr. XXXXX was not a network physician. The Petitioner's father contends that the Petitioner does not have

flat feet and that Dr. XXXXX is a network physician. He also says that Priority Health denied coverage because the service had not been pre-authorized.

The Petitioner's father cannot understand why Priority Health will not cover care that was recommended and was medically necessary.

Respondent's Argument

In its final adverse determination of November 6, 2007, Priority Health denied coverage for the orthotics, citing these provisions in the certificate to support its decision:

> **5.2 Requirements for Covered Services**
>
> Services covered by HMO must be:
>
> (1) Provided by the PCP [primary care physician] or arranged by the PCP or Participating Specialist and approved in advance by HMO, and
>
> (2) Medically necessary, and
>
> (3) A covered benefit, and
>
> (4) Not specifically excluded from coverage, and
>
> (5) Provided by a HMO Participating Provider, except in emergencies. [Emphasis added]
>
> *** * ***
>
> **6.9 Foot Care - Limitations and Exclusions**
>
> The following are not Covered Services:
>
> * * *
>
> (2) Orthotic devices; corrective shoes, supports and inserts unless attached to a brace or when ordered in conjunction with a diabetic foot condition and approved in advance according to HMO's guidelines.

Priority Health also referred to its Medical Policy DME-3, "Orthopedic Footwear," which states in part:

> Orthopedic shoes, foot orthotics or other or supportive devices of the feet are covered under the following conditions:

- When a shoe is an integral part of a leg brace and its expense is included as part of the cost of the brace.

- When therapeutic shoes are needed for a diabetic condition as outlined in this policy.
- As a prosthetic shoe as outlined in this policy.
- When ordered as a rehabilitative foot orthotic prescribed as part of post-surgical care or post traumatic casting care.

Priority Health says the Petitioner does not meet the criteria of the certificate or its medical policy for orthotics. In addition, Priority Health says it has no record of having received a request for prior authorization from the Petitioner's PCP before he received the orthotics. Priority Health also acknowledges that it incorrectly said that Dr. XXXXX was not a network provider at the time of service.

Priority Health believes it properly denied the Petitioner's request for retroactive authorization and coverage.

Commissioner's Review

The Commissioner carefully reviewed the arguments and documents the parties submitted. The issue in this case is whether Priority Health properly denied coverage for orthotics the Petitioner received from Dr. XXXXX.

Over the course of the Petitioner's grievance, Priority Health identified a number of bases for denying coverage for his orthotic devices, including the lack of prior authorization, the network status of the provider, and the Petitioner's diagnosis. However, the Commissioner finds that the reason given in Priority Health's November 6, 2007, final adverse determination (i.e., foot orthotics are not a covered benefit) is valid and upholds Priority Health's denial.

The Petitioner's certificate covers orthotic devices for the feet only in very limited circumstances. The requirements are found in Section 6.9, quoted above, which says that orthotics are only covered if attached to a brace or when ordered in conjunction with a diabetic foot condition and approved in advance. That limitation is also found in Section 6.12, "Durable

Medical Equipment, Supplies, Devices and Prosthetic Appliances – Limitations and Exclusions," which says:

> The following are not Covered Services:
>
> * * *
>
> (6) Orthotics, corrective shoes or shoe inserts unless attached to a brace or when ordered in conjunction with a diabetic foot condition and approved by HMO according to HMO guidelines.

A HMO like Priority Health is required under Section 3519(3) of the Insurance Code of 1956, MCL 500.3519(3), to provide "basic health services." Orthotics are not a basic health service as that term is defined in Section 3501(b) of the Insurance Code, MCL 500.3501(b), and HMOs are not required to provide them. As a result, HMO's are free to determine whether they will offer such items as orthotics and corrective shoes as a covered benefit or totally exclude them from coverage. The Petitioner's benefit plan does include some coverage for orthotics but when it comes to foot orthotics, Priority Health has chosen to limit that benefit to specific circumstances.

It is clear that Priority Health's certificate, in Sections 6.9 and 6.12 quoted above, excludes orthotics and corrective shoes, even when they are medically necessary as they appear to be in the Petitioner's case. Since it has not been shown that the Petitioner's orthotic is an integral part of a leg brace, is needed for a diabetic condition, or was prescribed as part of post-surgical care or post traumatic casting care, it is excluded from coverage.

Therefore, the Commissioner concludes that the Petitioner did not meet the requirements in Section 6.9 or 6.12 and finds that Priority Health's final adverse determination is consistent with its certificate.

V
ORDER

The Commissioner upholds Care Choices/Priority Health's November 6, 2007, final adverse determination in the Petitioner's case. Priority Health properly denied coverage for

orthotics provided April 9, 2007.

Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Since Care Choices surrendered it certificate of authority and is no longer licensed to conduct business as a health maintenance organization, Priority Health is now responsible for processing any Care Choices appeals under the Patient Right to Independent Review Act. These changes do not affect the Commissioner's Order in this external review. However, any ongoing correspondence or other actions concerning this Order should now be directed to Priority Health at the following address:

Priority Health
1231 East Beltline NE
Grand Rapids, MI 49525-4501